FAMILIES, PHYSICIANS, & ILLNESS

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Health care professionals and families face new and diverse challenges in the current health care market. With the move toward managed care, providers have been required to look for ways to make services more efficient. At the same time, families have struggled to find affordable coverage that meets their needs. Contemporary research has supplied important information about some of the effects relationships can have on health. The way relationships influence health has been addressed mostly by looking at the family system and families' interactions with health care providers. The understanding that has come from such research can be useful for families struggling with illness.

Family Relationships and Health

Different families react to illness in different ways; some are able to adjust while others are not. For some, the problems that come with illness can dominate family life and leave little energy for “normal” family activities. In other instances, family functioning and illness are dependent upon each other, such as when families only function adequately if someone is sick (Minuchin & Fishman, 1981). Most studies investigating families and health have focused on chronic illness since important interactions become more noticeable with time (e.g., Cohen, 1999; Knight, Green, & Hinson, 1997; Sellers, 2000). Within these studies, similar problems are seen repeatedly, and can be used as a model for how families react to illness. In general, dealing with stress has been identified as a significant challenge when chronic illness invades family life.

All families, at one time or another, will experience some type of stress. The idea of stress can be described in at least two different ways: (1) stress that affects an individual's well being; and (2) stress that affects relationships. Although both types of stress have been shown to adversely affect health, under-
standing the difficulties families experience with illness will be given particular attention. Families with chronic illness who cannot make necessary changes could hypothetically find themselves in a vicious cycle with stress. Specifically, if a family is not able to meet new challenges after a chronic illness is diagnosed, conflict is likely to ensue, which in turn increases family members’ stress and negatively affects health. As the health of family members worsens, resources may be stretched even further, starting the cycle over again.

When illness creates stress, the most noticeable effect is on the way the family organizes relationships. Roles that were well understood before the illness may no longer be relevant (Rolland, 1998; Sellers, 2000). For example, a father who is the sole provider of a family may be unable to work after a significant back injury. An ill family member may not even have a substantial role if hospitalization is a common occurrence (Cohen, 1999). In contrast, a child may take on the “sick role” in an attempt to stabilize family problems (Minuchin & Fishman, 1981).

When roles are affected by illness, rules about “who does what” often change (Cohen, 1999). These changes can be superficial, like deciding who takes out the garbage. If a parent is ill, deciding who is responsible to provide financially may be important. Also, when a parent is ill, the chain of command may be challenged as responsibilities are taken on by other family members. Boundaries between family members are also likely to change as problems are addressed (Cohen, 1999). For example, an oldest daughter who is required to care for younger brothers and sisters may come to feel detached from her siblings. Illness often demands changes in roles, rules, and boundaries; and families must be able to adapt in ways that promote the continuation of healthy relationships.

If a family is unable to meet challenges, dysfunctional patterns are likely as the family attempts to regain some level of stability. One way this may occur is through the formation of alliances that ultimately alienate family members. Rolland (1999) recounts a situation where a mother focused solely on her chronically ill child, which left the father feeling distant and uninvolved. Interestingly, it was only after asking about the parents’ families of origin that the author found both parents were acting in ways that had been modeled in their families. In another instance Rolland (1998) was asked by hospital staff to come into the intensive care unit (ICU) to resolve a conflict between the wife of a patient with heart disease and his highly involved mother. The staff felt that the mother was interfering with hospital procedure, and reported that they noticed every time a conflict between the mother and wife arose concerning each other’s level of involve-

**Opportunities for Marriage and Family Therapists**

The field of marriage and family therapy currently finds itself in need of establishing and protecting its standing in the modern health care market. This endeavor rests in part on the usefulness of marriage and family therapy (MFT) in improving dimensions of physical health. Other providers (e.g., psychologists) have already demonstrated that individual counseling can result in a reduction in physician visits (e.g., Kessler, Steinwachs, & Hankin, 1982). Law and Crane (2000) assert that if marriage and family therapy is to continue to succeed, treatment using MFT must be shown to have similar benefits. So far, much of the work that has looked at the impact of MFT on health has focused on how marriage and family therapists (MFTs) can work effectively within primary care settings (e.g., Seller, 2000).

Working in primary care settings would require that MFTs have some knowledge of physiological processes. Given the limited understanding of most MFTs in this area, additional training is needed to teach MFTs how to intervene. A practical way of providing this training is to bring physicians and MFTs together during discussions of family/illness interactions in an effort to increase the flow of information between professions (Saba, 2000). Another way to improve communication between providers is to have practitioners of all types within the same clinical setting. A number of authors have described success with this type of arrangement (e.g., Mauksch, 1999; Saba, 2000; Sellers, 2000). Regardless of the way practices are set up, sharing of information and collaboration are the first steps in providing more efficient care to patients and families.

With time, collaboration and joint training will allow boundaries between professions to become less visible (Mauksch, 1999).
ment, the patient reported greater chest pain. In this narrative Rolland focused on the coalitions within the immediate family and failed to distinguish that the mother, the wife, and the ICU staff all attempted to gain his support for their positions during his visit. The fundamental problem with the formation of alliances is that overall support is less available, and as support decreases poor outcomes increase (Williams, Frankel, Campbell, & Deci, 2000).

Although the whole family is affected by illness, women are typically affected the most. Having traditionally been responsible for care giving, women may become overburdened when required to take on additional responsibilities that come with chronic illness. This seems likely to occur even in families who value equal division of labor since such transitions often force a change to more traditional roles (McGoldrick, 1989). This is compounded by the fact that women tend to be more attentive to suffering within the family, which also increases their risk of stress related problems (Kiecolt-Glaser & Newton, 2001). This understanding requires that particular attention be given to the experience of women.

It is also important to remember that beliefs the family holds about illness can impact a family’s reaction. Beliefs are capable of both hindering and facilitating adaptation to the presence of illness. Rolland (1998) provides an exhaustive list of beliefs that contribute to a family’s reaction. Among these are beliefs related to the normality of illness, interactions with health care providers, mind-body relationships, control over outcomes, ideas about the cause of disease, cultural views of illness, expected roles and behavior, and the willingness to shift beliefs as needed. Though addressing each of these areas is beyond the scope of this work, a poignant example can be seen in families’ beliefs about the cause of an illness, especially when one member is somehow blamed for causing the illness. To illustrate this, Rolland (1998) gives the example of someone who states that the nagging of their spouse caused them to have a heart attack. In the case of a life threatening illness, Rolland (1998) argues that beliefs relating to blame have the potential to hold a family member accountable for murder if the patient dies. Beliefs such as this make successful management more difficult, and severely limit the coping resources available.

One way that beliefs can facilitate healing is if families are able to create a “shared meaning” about the illness (Seller, 2000). This includes not only their views about the illness itself but also how the family will go about working with health care professionals (Rolland, 1998). When a family member has a chronic illness, frequent visits to health care providers is the norm. Boundaries between the

By being prepared to address psychosocial aspects of illness, physicians can reduce the stigma associated with this topic. This can have a positive impact in reducing the difficulty physicians have getting patients to make appointments when referrals are made to mental health providers. In addition, MFTs will be prepared to address problems that are common to specific illnesses. The blending of professional boundaries can influence positive changes in both professions as a systemic view of illness is refined.

Even in the absence of chronic illness, helping families function better can influence health. The findings of Law and Crane (2000) have been instrumental in the effort to demonstrate this effect. Their work has shown a significant 21.5 percent decrease in physician visits among those who participated in MFT. Law and Crane also reported a 30.5 percent decrease in utilization by family members of an identified patient who participated but were not the focus of therapy. To date, these findings remain the most impressive evidence that MFT can have a positive influence on general health care use.

The work of Law and Crane provides at least a foundation on which MFTs can build an argument for the continued inclusion of marriage and family therapy in the primary care dominated system. As evidence begins to mount that marriage and family therapy is beneficial to general health, the field will likely become more valued in the health care system. This will allow MFTs to work in either primary care settings or in private practice while concurrently being recognized as influential in the greater health care system. Regardless of the setting, the future of marriage and family therapy in the health care system appears to be promising.
family and "outsiders" need to be flexible as health care providers regularly participate in family interactions. This can be difficult for families who have little faith in the medical profession, or for families who discourage talking about concerns outside the immediate family. It follows that creating a shared meaning entails more than just beliefs; this process also implies the possibility of practical changes in the way the family operates.

Another crucial factor in predicting how well families cope seems to be the fit among the family's strengths and weaknesses and the demands that come with the illness (Rolland, 1998). For example, some families may be able to manage minor illnesses that can be cared for at home, while at the same time lack the flexibility needed to manage chronic illness that requires intrusive medical interventions. In effect, this means that while families facing specific illnesses can expect to face similar problems, their response will likely be very different. Some families will need to make radical changes, while others will find they are able to meet demands without much effort.

When families experience illness related stress, conflict is typical as the family tries to find new ways to cope (Sellers, 2000). Some families will have sufficient resources to avoid major conflict, while others will find themselves amidst perpetually disagreement and turmoil. Families who are able to meet the challenges are generally those who find ways to "put the disease in its place" (Cohen, 1999), meaning the family is able to maintain a sense of normality in family life. Successful adaptation requires that the family be able to address individual members' needs and at the same time provide proper care for the illness.

While this is the ideal, families will occasionally give in and allow the illness to take over. At times "the illness may demand so much that it becomes the organizing principle of family life...dominating system, structure, and function" (Cohen, 1997, p.149). Knight, et al. (1997), provide an excellent overview of how health problems can dominate family life. The authors explain that health concerns can "assume functions in communication, feedback loops, and handling of emotional reactivity [and]...family dynamics are involved in circular interactions with the symptoms, sometimes in a spiraling cycle with exacerbation, and the various factors serve to perpetuate the symptoms" (p.143).

Knight, et al. (1997), show how relationship issues can exacerbate symptoms and promote changes. In the case of a married couple, when a change to more equal division of labor was desired, the patient was observed to experience an increase in pain. Following this increase in pain, the partner took on additional responsibilities. Families that organize around an illness may feel they are responding adequately; nonetheless, this response is by nature ineffective and ultimately risks the health of family members (Cohen, 1999).

A discussion of how families react to illness leads naturally to a discussion of how these reactions can affect physical health. Cohen (1999) cites evidence that shows family dynamics have a significant effect on the course of asthma, abdominal illnesses, cystic fibrosis, and diabetes. As has been mentioned, family relationships have also been shown to affect symptom intensity in the cases of pain and heart disease. Franks and colleagues argue that depression, which can result from illness demands (Heru, 2000), increases cardiovascular risk behaviors such as smoking, lack of exercise, and poor diet (as cited in Williams et al., 2000). In addition, the regulation of diseases such as hypertension and diabetes suffer with depression (Mauksch, 1999). Given the diverse ways family functioning affects health, helping families to cope has great potential to reduce the impact of illness.

Interactions with Health Care Professionals

In working with patients and their families, physicians have a unique opportunity to promote healthy responses to illness. Although a focus on biological pathology continues to dominate medicine, many professionals are now realizing the importance of recognizing the influence of relationships on health (Williams et al., 2000). Patients, on the other hand, often are still attracted to the biological explanations that prevail in the medical field (Jabar, Trilling, & Kelso, 1997). Nevertheless, physicians can act in ways that promote family
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Involvement, as well as subtly influence patients' beliefs about the role of health care providers. If done appropriately patients will often feel more control over the illness, which will ultimately facilitate healing.

A challenge to this approach is found in a number of "unspoken" rules that seem to govern interactions with health care providers. Among these are that the physician is the expert, the physician is responsible for change, and the physician's classification of symptoms is enough to determine a successful treatment (Jabar et al., 1997). This last rule essentially refers to the biomedical model, which assumes that identifying a biological cause is all that is needed for successful treatment. The first two rules, on the other hand, reflect power dynamics, which tend to be more problematic in health care. If change to a more global approach is desired, unspoken rules need to be explicit in the minds of health care providers and families. Only then can the status quo be challenged. This seems to be especially true for considerations of the use of power.

Goodrich and Wang (1999) argue that "prestige awarded to the profession plus greater income, education, and range of experience" provide the foundation for unequal power in relationships with physicians (p.449). The authors conclude that despite other social issues (e.g., the patient may be more wealthy), the overall balance of power typically favors the physician. Frey (1999) observed that beginning medical students frequently return from their first vacation amazed that friends and family treat them as if they hold greater authority, even though they have very little training. According to Frey, experiences like this shape physicians' views of their position in society, which forces a choice to be made about how to use the authority afforded them. Unfortunately, power all too frequently follows the unspoken rules listed previously.

Although society is implicated in the misuse of power, medical training can also be viewed as providing doctors with abilities beyond their training. Saba (2000) argues that the training of physicians fosters the belief that physicians can "control disease, and by logical extension control people with disease" (p.356). Goodrich and Wang (1999) observe that the misuse of power by hospital faculty infects later interactions between medical residents and patients. It follows that efforts to challenge the misuse of power will be most effective when incorporated into medical education and training (Goodrich & Wang, 1999; Saba, 2000). This would help students to both learn about effective use of power and witness advantages through interactions with faculty.

Supported in training and society, misuse of power is all too apparent. One of the most noticeable ways this is seen is in the focus on compliance above all else. Focusing heavily on compliance is closely associated with the "physician-centered" model. This model is characterized by "explicitly or implicitly [pressuring] the patients to behave in specific ways...and involves physicians assuming that their authority is enough to motivate patients" (Williams et al., 2000, p.81). Although some physicians who use this approach allow the patient the final decision about treatment, Goodrich and Wang (1999) contend that since the physician determines which treatments to present and asserts greater knowledge about the illness, the patient remains at a disad-
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vantage. Williams, et al. (2000), reviewed numerous articles which show that limiting the focus to issues of compliance does not facilitate recovery. In fact, patients were found to be less likely to actively engage in treatment when the physician uses such tactics.

Consistent with the physician-centered approach, decisions about illness usually exclude input from the family. In light of the impact of family relationships on illness, the patient’s family necessarily needs to be somehow included in treatment planning. Williams, et al. (2000), argue for an approach that includes the family and requires the physician to be active in this effort. This approach is referred to as “relationship-centered,” and emphasizes a need for the physician to empathize with the family and share power in treatment decisions. As described by Williams, et al., the physician intervenes by “taking full account of their perspectives, affording choices, offering information, encouraging self-initiation, providing a rationale for recommended actions, and accepting the patients’ decisions” (p.81). The main idea is that the patient and family are encouraged to be actively involved in decision-making and treatment. Allowing the patient and family to participate more fully has been shown to positively influence “program attendance, smoking cessation, glucose control, long-term exercise, maintained weight loss, and adherence to medication prescriptions” (Williams, et al., 2000, p.84). The most important contribution of this approach to health care is that physicians are required to include all relevant parties (Goodrich & Wang, 1999), thereby eliminating the isolation of the family.

Saba (2000) suggests that shifting to relationship centered treatment requires a change in medical training. Two of the suggestions he presents are particularly noteworthy. The first suggestion is that physicians should be taught to “think relationally.” This would call for the physician to spend time with the family discussing the illness and the family’s ability to cope with accompanying stressors. If the family seems to be having difficulty coping, the physician can learn to emphasize strengths (Goodrich & Wang, 1999; Wetzel, 1998), as well as, enlist social support (Wetzel, 1998).

The second noteworthy recommendation is that physicians should learn to discuss their own beliefs about illness and the process of healing. Rolland (1998) suggests that one of the most important predictors of compliance is the fit between the beliefs of patients and physicians. He asserts that one common difference is likely to be found in the desire of the patient to recruit social support and the contrary biomedical beliefs of the physician. However, the opposite is also possible if a physician is relationship oriented and the family prefers a biomedical explanation. When this occurs, it is recommended that physicians validate beliefs of the patient, even if stress will need to be addressed at some time (Jabar, et al., 1997). By listening to client’s beliefs about illness, physicians are given the opportunity to show empathy and share their own thoughts about illness. An exchange of ideas can then occur that allows those involved to discover and, if needed, improve the fit between their beliefs (Rolland, 1998). Outcomes will also likely improve since the family and the provider will be more capable of working together to manage the illness.

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physician is unable to find a biological cause for symptoms. Such cases require a discussion of the impact of psychosocial factors. Unfortunately, this may be a problem physicians will commonly encounter in practice. In fact, Kroenke and Mangelsdorff found that only 16 percent of those with physical complaints were found to have a diagnosable biological problem (as cited in Ruelhman, Lanyon, & Karoly, 1998). Jabar, et al. (1997), describe a common pattern that emerges in cases where psychosocial factors are found to be influencing illness. According to the authors, patients will generally hold to the belief that biological problems are causing physical symptoms. When a physician determines that psychosocial factors are influential and discounts the beliefs of the patient, the tendency is for the patient to argue against the physician’s position. This, in turn, leads to the physician labeling the patient as “somatizing” or “difficult.” Labeling the patient creates an impasse and inspires the patient to search for another doctor, thus starting the cycle all over again. The authors suggest that to avoid impasses, physicians should become active in changing power dynamics, work to change rigidly held beliefs, and avoid the unspoken rules discussed before, thereby empowering clients and facilitating change.

The ability of the physician to help families cope becomes problematic as time constraints are increasingly imposed by managed care. Consequently, current health care trends have made relationship oriented approaches difficult to employ (Goodrich & Wang, 1999), leading some physicians to reduce related efforts to the smallest amount possible (Saba, 2000). As the need for intervention in family systems becomes recognized and the demands on physician’s time become more intense, the burden of intervention will likely fall on mental health professionals. Regardless of who is responsible for intervention, implementing strategies to address interpersonal interactions has great potential to positively influence families’ experience with illness. Thus, it becomes the responsibility of those involved with illness to be aware of common processes and have an understanding of their place in addressing concerns that may arise. Only by so doing can professionals and families hope to be effective in meeting the demands of illness.

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**References**


